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ABSTRACT

This report compares the Social Security Administration's Disability Insurance (DI) program and the practices of the private sector and other countries in helping people with severe disabilities return to work. Information was gathered in in-depth interviews and a review of policy documents and program data at three private sector disability insurers: UNUMProvident, Hartford Life, and CIGNA. Program officials and other experts on the disability systems of Germany, Sweden, and the Netherlands were interviewed. Disability systems of the private insurers and the countries reviewed integrate return-to-work considerations early after disability onset and throughout the eligibility assessment process. This involves determining, as well as enhancing, the ability of each claimant to return to work. In addition, these systems provide incentives for claimants to take part in vocational rehabilitation programs and to obtain appropriate medical treatment and for employers to provide work opportunities for claimants. Managers of these systems have developed techniques to use staff with the appropriate expertise to provide return-to-work assistance to claimants in a cost-effective manner. In comparison, the Social Security Administration was found to have an eligibility determination process that concentrates on applicant's incapacities, an "all-or-nothing" benefits structure, and return-to-work services offered only after a lengthy determination process. (CR)

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Other Programs May Provide Lessons for Improving Return-to-Work Efforts

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SSA Disability: Other Programs May Provide Lessons for Improving Return-to-Work Efforts

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to discuss the practices of the private sector and other countries in helping people with severe disabilities return to work. Each month the Social Security Administration's (SSA) Disability Insurance (DI) program pays over $4 billion in cash benefits to people with disabilities. The DI beneficiary population has grown significantly over the past 15 years, increasing by 67 percent, while benefit payments have nearly tripled. This growth has contributed to the DI trust fund's projected insolvency in 2023. Yet, during this period of program growth, numerous technological and medical advances, combined with changes in society and the nature of work, have increased the potential for some people with disabilities to return to, or remain in, the labor force. Many beneficiaries with disabilities indicate that they want to work and be independent, and many can work if they receive the supports they need, yet fewer than one-half of 1 percent of DI beneficiaries leave the rolls each year to return to work.

The U.S. private sector, as well as other countries, has designed disability systems to help disabled workers return to work. In recent years, a growing number of private insurance companies have been focusing on developing and implementing strategies for controlling disability costs by enabling people with disabilities to return to work. Disability programs financed by social insurance systems in other countries also focus on return to work and have implemented practices similar to those in the U.S. private sector.

Today I would like to discuss how disability systems in the private sector and other countries encourage and facilitate return to work in three key areas: (1) the eligibility assessment process, (2) work incentives, and (3) staffing practices. I will describe these three elements for U.S. private sector disability insurers and for other countries' social insurance systems and compare the practices of both with those of the DI program. We are comparing these practices with those of the DI program because the work experience of the DI population is most comparable to that of employees covered under private disability insurance. However, many of the comparisons discussed would be applicable as well to SSA's other disability program, Supplemental Security Income (SSI).

To develop this information, we conducted in-depth interviews and reviewed policy documents and program data at three private sector

disability insurers: UNUMProvident, Hartford Life, and CIGNA.[1] We also interviewed program officials and other experts on the disability systems of Germany, Sweden, and The Netherlands and reviewed policy documents and studies of these programs. This work updates and expands on our previous work in this area.[2]

In summary, the disability systems of the private insurers and the countries we reviewed integrate return-to-work considerations early after disability onset and throughout the eligibility assessment process. This involves both determining—as well as enhancing—the ability of each claimant to return to work. In addition, these systems provide incentives for claimants to take part in vocational rehabilitation programs and to obtain appropriate medical treatment and for employers to provide work opportunities for claimants. Managers of these other systems also explained to us that they have developed techniques—such as separating (or "triaging") claims—to use staff with the appropriate expertise to provide return-to-work assistance to claimants in a cost-effective manner. Although these practices are common to the private sector insurers and the countries whose systems we examined, limited data exist on the cost-effectiveness of these approaches.

SSA may face greater difficulty in returning some of its beneficiaries to work than the private sector insurers, since DI covers a broader population than the private insurers. Nevertheless, opportunities exist to help disabled workers remain at or return to the work place. In recognition of these opportunities, SSA has recently begun placing greater priority on returning beneficiaries to work. Moreover, the new Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket to Work Act), by expanding access to vocational rehabilitation services, is expected to enhance work incentives for people with disabilities. However, fundamental policy weaknesses in the DI program remain unchanged. As we have reported in the past, these weaknesses include an eligibility

[1]Taken together, these three insurers have experience not only in long-term, stand-alone disability insurance, but also in integrating short- and long-term disability insurance with workers' compensation and, in one instance, with health care. These insurers are also among the largest long-term disability insurers in the country, together covering about 52 percent of the long-term U.S. private disability insurance market in 1997. We focused our analysis on the population of applicants and beneficiaries whose disabilities are of such severity that they would likely qualify for SSA's disability benefits. In addition, we focused our review on private insurers' group disability insurance policies, which contain return-to-work incentives.

[2]See *SSA Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs* (GAO/HEHS-96-133, July 11, 1996).

determination process that concentrates on applicants' incapacities, an "all-or-nothing" benefits structure, and return-to-work services offered only after a lengthy determination process.

To address these policy weaknesses, we continue to believe—as we recommended in 1996—that SSA should develop a comprehensive return-to-work strategy. In developing the strategy, SSA can draw upon the experiences of other systems to identify elements of a new federal disability system that could help each individual realize his or her productive potential without jeopardizing the availability of benefits for people who cannot work. Having identified these elements, SSA would then be in a position to determine the legislative and regulatory changes needed to test and evaluate the effectiveness of these practices in the federal disability system.

Background

DI provides monthly cash benefits to workers who are unable to work because of severe long-term disability. Established in 1956, DI is an insurance program funded by payroll taxes paid by workers and their employers into a Social Security trust fund. Workers who have worked long enough and recently enough become insured for DI coverage. In addition to cash assistance, DI beneficiaries receive Medicare coverage after they have received cash benefits for 24 months. In 1999, 4.9 million disabled workers received DI cash benefits totaling about $46.5 billion, with average monthly cash benefits amounting to $755 per person.[3]

To meet the definition of disability under DI, an individual must have a medically determinable physical or mental impairment that (1) has lasted or is expected to last at least 1 year or to result in death and (2) prevents the individual from engaging in substantial gainful activity. Individuals are considered to be engaged in substantial gainful activity if they have countable earnings at or above a certain dollar level.[4] Moreover, the statutory definition specifies that, for a person to be determined to be disabled, the impairment must be of such severity that the person not only

[3]In the same year, DI also paid about $4.9 billion in cash benefits to about 1.7 million spouses and children of disabled workers.

[4]Regulations currently define substantial gainful activity (SGA) as employment that produces countable earnings of more than $700 a month for nonblind disabled individuals. The SGA level for individuals who are blind is set by statute and indexed to the annual wage index. Currently, the SGA for blind individuals is $1,170 of countable earnings. SSA deducts from gross earnings the cost of items a person needs in order to work and the value of support a person needs on the job because of the impairment before deciding if work is considered SGA.

is unable to do his or her previous work, but, considering his or her age, education, and work experience, is unable to do any other kind of substantial work that exists in the national economy. SSA pays state disability determination service (DDS) agencies to determine whether applicants are disabled. The program offers people on the DI rolls incentives that are intended to encourage beneficiaries to return to work—and, potentially, to leave the rolls. For example, the DI work incentives provide for a trial work period in which a beneficiary may earn any amount for 9 months within a 60-month period and still receive full cash and medical benefits.

Historically, SSA has given little emphasis to assisting beneficiaries in returning to work, and we have made a number of recommendations for improvement. For example, in 1996, we identified weaknesses in SSA's return-to-work efforts and recommended that SSA intervene earlier to foster a greater emphasis on assisting disabled applicants and beneficiaries in returning to the workforce.[5] We also reported that the disability determination process encourages work incapacity because applicants have a strong incentive to emphasize their limitations in order to qualify for benefits. In addition, we observed that the often lengthy and cumbersome application process may itself reinforce applicants' perceptions of their inability to work.[6]

SSA has recently begun to place higher priority on emphasizing return to work for DI beneficiaries. For example, SSA recently established the Office of Employment Support Programs to promote the employment of disabled beneficiaries. In addition, the Ticket to Work Act is expected to enhance work opportunities for people with disabilities. For example, this new act expanded eligibility for Medicare for DI beneficiaries and created a "Ticket to Work" voucher program that will allow beneficiaries a greater choice of vocational rehabilitation and employment service providers. SSA has also funded partnership agreements in 12 states that are intended to help the states develop services to increase the employment of DI beneficiaries.

[5]See GAO/HEHS-96-133, July 11, 1996.

[6]See *SSA Disability: Program Redesign Necessary to Encourage Return to Work* (GAO/HEHS-96-62, Apr. 24, 1996).

Private Disability Insurers Implement Return-to-Work Practices to Control Costs

Private insurers provide disability insurance to a selected portion of the U.S. working population. Unlike SSA, private sector insurers are able to choose the industries to which they market their policies. The characteristics of the private insurers' beneficiaries can also differ from those of SSA's beneficiaries because private insurers can allow employers who purchase their disability policies to vary coverage by type of impairment or by class of employee. For example, employers generally choose to limit coverage for mental impairments to a maximum of 24 months.[7] Employers may also choose to provide long-term disability coverage for only their white collar employees, rather than for all their employees.

The private disability insurance industry, moreover, provides benefits to many individuals who are not as severely disabled as the beneficiaries of the DI program. However, for the insurers reviewed, almost two-thirds of those receiving private long-term disability benefits also received DI benefits.[8] This group of beneficiaries, in the cases of the two insurers that provided us with comparable data, was composed of a slightly higher proportion of female and older beneficiaries than the overall DI population. All the insurers had a lower proportion of beneficiaries with mental impairments than the DI population.

Some private sector organizations have recognized the potential for reducing disability costs through an increased focus on returning people with disabilities to productive activity. To accomplish this comprehensive shift in orientation, the private disability insurers have begun developing and implementing strategies for helping claimants return to work as soon as possible, when appropriate. Although the private sector insurance companies expect a positive effect on return-to-work outcomes from these strategies, it is too early to fully measure the effect of these changes. In many cases, return-to-work processes have only recently been implemented. Moreover, although the private insurers are now including return-to-work provisions in the standard contracts that they are writing, a large number of employees are still insured under prior contracts that lack

[7]The 24-month limitation on mental impairments does not include time spent in a hospital or mental institution. Also, the three insurers vary in their descriptions of the types of mental illness that are covered under this special limitation. One insurer excludes bipolar affective disorders, psychotic disorders, and schizophrenia from this limitation. In contrast, the DI program does not have time-limited benefits for beneficiaries with mental impairments. In 1999, 26.8 percent of DI disabled workers with an available diagnosis had mental disorders.

[8]For claimants who receive both private and DI benefits, the private insurers reduce their disability payments by the amount of the DI payment.

these provisions. While the insurers could not provide us with comprehensive cost-effectiveness studies, their initial return-to-work rates are promising. The private insurers reported that, in 1999, between 2 and 3 percent of their long-term disability beneficiaries who also received DI benefits returned to work or were terminated from the private sector disability benefit rolls because they were assessed as having the capacity to work.

Other Countries Also Invest in Return-to-Work Efforts

In contrast to the private sector, which covers a selected portion of the U.S. working population, the experiences of Germany, Sweden, and The Netherlands show that return-to-work strategies are applicable to a population with a wide range of work histories, job skills, and disabilities. However, these disability systems operate in a somewhat different social and political context than the DI program. For example, public health care programs in these countries ensure that the retention of health insurance is not an issue in a worker's decision on whether to apply for benefits, participate in rehabilitation, or attempt returning to work. In addition, disability systems in these countries offer short-term as well as long-term benefits, which provides an important basis for comprehensive disability case management.

The social insurance disability programs in these countries have invested in return-to-work efforts and have implemented practices similar to those in the U.S. private sector. While the German social insurance system has had a long-standing focus on the goal of "rehabilitation before pension," the reorientation of Sweden and The Netherlands toward a return-to-work focus has occurred mostly within the past decade. Although rigorous studies demonstrating the cost-effectiveness of German, Swedish, or Dutch programs generally do not exist, some limited studies and data indicate positive results from the return-to-work approach in these disability insurance systems.[9]

[9]For example, a 1990-92 study of certain return-to-work practices used by Sweden's social insurance offices concluded that social insurance costs had been reduced by returning people to the workplace sooner. Practices assessed included early screening and contact with disabled individuals.

The Eligibility Assessment Process Integrates Return-to-Work Considerations Throughout

All the private disability insurers and the countries we reviewed have developed an eligibility process that includes assessing and enhancing the ability of claimants to work throughout the process. To enable claimants to return to work as quickly as possible, insurers incorporate return-to-work considerations early in the assessment process and throughout a customized evaluation of each claimant's initial and continuing eligibility for benefits. In contrast, SSA's return-to-work efforts occur after its eligibility assessment process. (See table 1.)

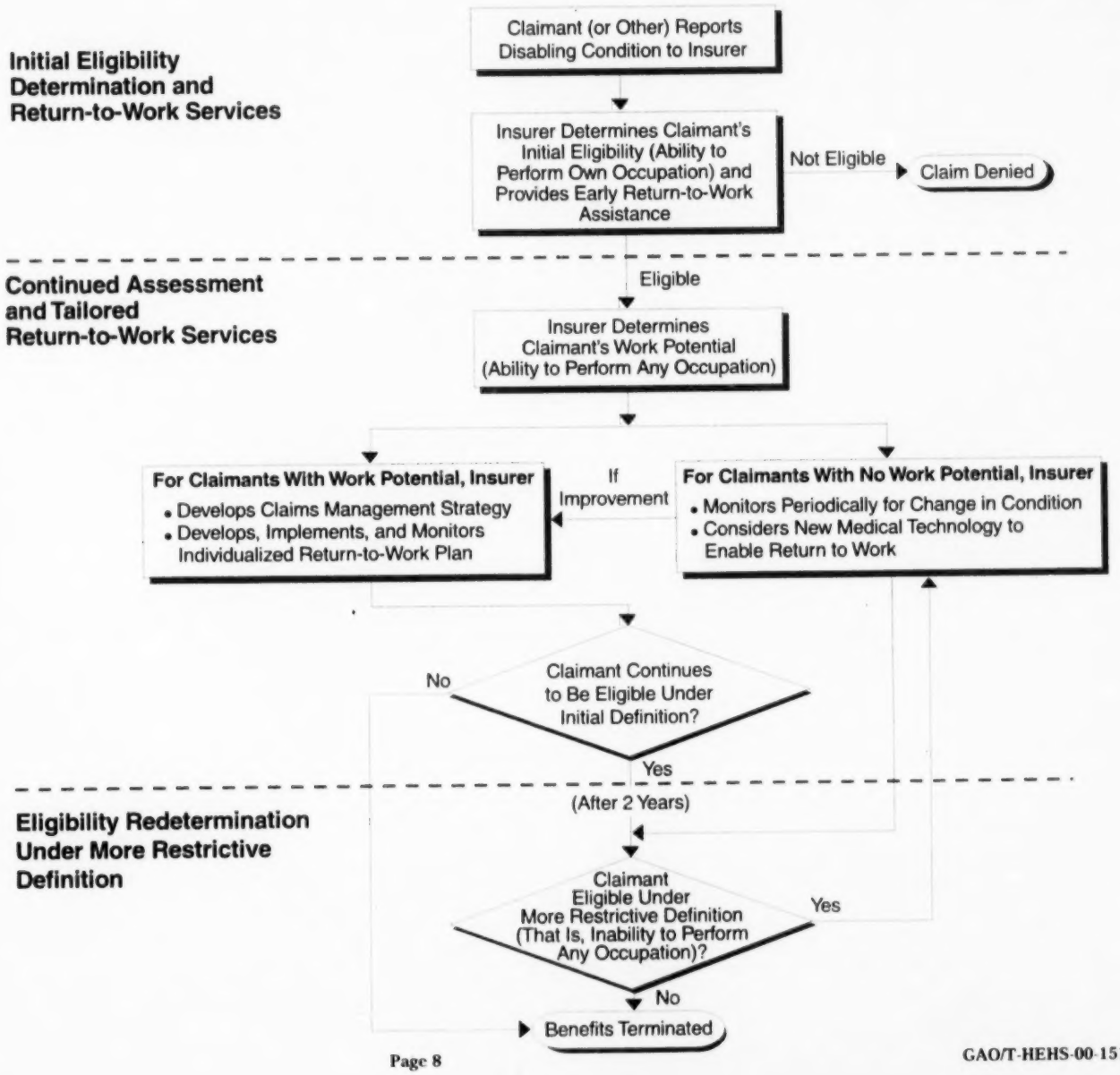
Table 1: Comparison of Eligibility Assessment Process Features of Private Insurers and Other Countries With Those of SSA

Process feature	Private insurers and other countries	SSA
Disability definition	Definition of disability shifts over specified time period from less to more restrictive, recognizing the possibility of improvement in the capacity to work through provision of supports and services, such as retraining.	"All-or-nothing" definition characterizes individuals as either unable to work or having the capacity to work.
Early intervention	Intervention occurs soon after disability onset to identify return-to-work needs.	There is a long delay in providing services because only individuals who have been awarded benefits—following an often lengthy assessment process—are eligible for return-to-work services.
Ongoing assessment of work potential	Work capacity is periodically monitored and reassessed, focusing on returning those with work potential to work.	There is no integration of return-to-work considerations into either the initial or the continuing eligibility assessment process.

Private Insurers Incorporate Return-to-Work Efforts From the Beginning of the Assessment Process

All the private insurers we observed incorporate return-to-work considerations early in the assessment process to assist claimants in their recovery and in returning to work as soon as possible. With the initial reporting of a disability claim, these insurers, when appropriate, immediately set up the expectation that the claimant will return to work. The insurers' process for assessing and assisting a claimant's ability to work is illustrated in figure 1.

Figure 1: Private Disability Insurers' Eligibility Assessment Process


Initial Eligibility Determination and Return-to-Work Services
Claimant (or Other) Reports Disabling Condition to Insurer
Insurer Determines Claimant's Initial Eligibility (Ability to Perform Own Occupation) and Provides Early Return-to-Work Assistance
Not Eligible
Claim Denied
Continued Assessment and Tailored Return-to-Work Services
Eligible
Insurer Determines Claimant's Work Potential (Ability to Perform Any Occupation)
For Claimants With Work Potential, Insurer
• Develops Claims Management Strategy
• Develops, Implements, and Monitors Individualized Return-to-Work Plan
If Improvement
For Claimants With No Work Potential, Insurer
• Monitors Periodically for Change in Condition
• Considers New Medical Technology to Enable Return to Work
No
Claimant Continues to Be Eligible Under Initial Definition?
Yes
(After 2 Years)
Eligibility Redetermination Under More Restrictive Definition
Claimant Eligible Under More Restrictive Definition (That Is, Inability to Perform Any Occupation)?
Yes
No
Benefits Terminated

After receiving a claim, the private insurers' assessment process begins with determining whether the claimant meets the initial definition of disability. In general, for all the private sector insurers we studied, claimants are considered disabled when, because of injury or sickness, they are limited from performing the essential duties of their own occupation, and they earn less than 60 to 80 percent of their predisability earnings, depending upon the particular insurer.[10] As part of determining whether the claimant meets this definition, the insurers compare the claimant's capabilities and limitations with the demands of his or her own occupation and identify and pursue possible opportunities for accommodation—including alternative jobs or job modifications—that would allow a quick and safe return to work. A claimant may receive benefits under this definition of disability for up to 2 years.[11]

As part of the process of assessing eligibility according to the "own occupation" definition, insurers directly contact the claimant, the treating physician, and the employer to collect medical and vocational information and initiate return-to-work efforts, as needed. Insurers' contacts with the claimant's treating physician are aimed at ensuring that the claimant has an appropriate treatment plan focused, in many cases, on timely recovery and return to work. Similarly, early contact with the claimant's employer is used to encourage the employer to make accommodations for claimants with the capacity to work.

If the insurers find the claimant initially unable to return to his or her own occupation, they provide cash benefits and continue to assess the claimant to determine if he or she has any work potential. For those with work potential, the insurers focus on return to work before the end of the 2-year period when, for all the private insurers we studied, the definition of disability becomes more restrictive: after 2 years, the definition shifts from

[10]The private insurers generally define one's "own occupation" as the occupation a person is routinely performing at onset of disability. They generally assess how the claimant's own occupation is performed in the national economy, rather than how the work is performed for a specific employer or at a specific location. Two insurers have expanded their "own occupation" definition of disability to include a reasonable alternative position. These insurers require that a claimant who is judged able to do so accept a reasonable alternative position—a job in the same general location offered by the claimant's current employer—or risk losing cash benefits. The claimant must be qualified to perform this alternative position—which must pay the claimant more than 60 to 80 percent of predisability earnings, depending upon the insurer—given his or her education, training, or experience.

[11]Our review of group disability insurance policies focused on those with an "own occupation" definition of disability that changes to an "any occupation" definition after 2 years.

an inability to perform one's own occupation to an inability to perform any occupation for which the claimant is qualified by education, training, or experience. Claimants may be found ineligible for benefits under the more restrictive definition.[12]

The private insurers' shift from a less to a more restrictive disability definition after 2 years reflects the changing nature of disability and allows a transitional period for insurers to provide financial and other assistance, as needed, to help claimants with work potential return to the workforce. During this 2-year period, the insurer attempts to determine the best strategy for managing the claim. Such strategies can include, for example, helping plan medical care or providing vocational services to help claimants acquire new skills, adapt to assistive devices to increase functioning, or find new positions. For those requiring vocational intervention to return to work, the insurers develop an individualized return-to-work plan, as needed. Basing the continuing receipt of benefits upon a more restrictive definition after 2 years provides the insurer with leverage to encourage the claimant to participate in a rehabilitation and return-to-work program. Indeed, the insurers told us that they find that claimants tend to increase their efforts to return to work as they near the end of the 2-year period.

If the insurer initially determines that the claimant has no work potential, it regularly monitors the claimant's condition for changes that could increase the potential to work and reassesses after 2 years the claimant's eligibility under the more restrictive definition of disability. In addition, the insurer looks for opportunities to assist these claimants when changes in medical technology, such as new treatments for cancer or AIDS, may enable them to work.

The private insurers that we reviewed told us that they customize their assessment and enhancement of a claimant's ability to work throughout the duration of the claim. To do this, disability insurers use a wide variety of tools and methods when needed. Some of these tools, as shown in tables 2 and 3, are used to help ensure that medical and vocational

[12]The private insurers generally use the same "own occupation" definition for short- and long-term disability benefits. However, in the case of long-term benefits, the definition shifts to the "any occupation" definition after 2 years. When applying the "any occupation" definition, private insurers generally try to identify several occupations that exist locally that could provide a sufficient salary for the claimant. However, the insurer is obligated only to identify occupations with a sufficient salary in the national economy and not to find specific job openings or place the claimant in a new position.

information is complete and as objective as possible. For example, insurers consult medical staff and other resources to evaluate whether the treating physician's diagnosis and the expected duration of the disability are in line with the claimant's reported symptoms and test results. Insurers may also use an independent medical examination or a test of basic skills, interests, and aptitudes to clarify the medical or vocational limitations and capabilities of a claimant. In addition, insurers identify transferable skills to compare the claimant's capabilities and limitations with the demands of the claimant's own occupation. This method is also used to help identify other suitable occupations and the specific skills needed for these new occupations when the claimant's limitations prevent him or her from returning to a prior occupation. Included in these tools and methods are services to help the claimant return to work, such as job placement, job modification, and retraining.

Table 2: Tools and Methods Used to Provide Medical Assessment

Task	Tools and methods
Assess diagnosis, treatment, and duration of the impairment and begin developing a treatment plan focused on returning the claimant to work promptly and safely.	Consultation of medical staff and other resources, including current medical guidelines describing symptoms, expected results from diagnostic tests, expected duration of disability, and treatment
Assess the claimant's cognitive skills.	Standardized mental tests
Validate the treating physician's assessment of the impairment's effect on the claimant's ability to work and the most appropriate treatment and accommodation.	Review of the claimant's file, generally by a nurse or a physician who is not the claimant's treating physician
Verify diagnosis, level of functioning, and appropriateness of treatment.	Independent medical examination of the claimant by a contracted physician
Evaluate the claimant's ability to function, determine needed assistance, and help the claimant develop an appropriate treatment plan with the physician.	Home visits by a field nurse or investigator or accompanied doctor visits
Assess the claim's validity.	Home visits and interviews with neighbors or others who have knowledge of the claimant's activities

Table 3: Tools and Methods Used to Provide Vocational Assessment and Assistance

Task	Tools and methods
Identify transferable skills, validate restrictions on and capabilities for performing an occupation, and identify other suitable occupations and retraining programs.	-- Test basic skills, such as reading or math. -- Determine interests and aptitudes. -- Evaluate functional capacities associated with an occupation, such as lifting, walking, and following directions. -- Compare functional capacities, work history, education, and skills with the demands of an occupation.
Enhance work capabilities and help develop job-seeking skills.	-- Provide resume preparation, development of job-seeking skills, and help with job placement. -- Assist in obtaining physical, occupational, or speech therapy and access to employee assistance, support groups, or state agency vocational rehabilitation or other community services. -- Identify and fund on-the-job training or other educational courses.
Assess ability to perform own or any occupation, assess potential for accommodation, and determine whether sufficient salary is offered locally or nationally for a suitable occupation.	-- Observe and analyze the essential duties of the claimant's own occupation, another occupation for the same employer, or an occupation of a prospective employer. -- Determine the general availability and salary range of specified occupations. Identify for a specified occupation the potential employers and related job descriptions, salary range, and openings.
Reaccustom claimant to a full work schedule and enable claimant to overcome impairment and return to work.	-- Provide work opportunities for the claimant to gradually resume his or her job duties. -- Procure devices to assist with work or otherwise help to modify the job.

Other Countries Also Provide Return-to-Work Assistance Early After Disability Onset and Throughout the Assessment Process

The countries we studied also begin assessing return-to-work needs soon after the onset of a disabling condition and integrate return-to-work assistance that is tailored to meet individual needs throughout the assessment process. These countries also provide short-term benefits on the basis of a person's inability to perform his or her current job because of illness or injury. These short-term disability benefits—which may be granted for a year or more—are similar to the private insurers' provision of benefits during the 2-year "own occupation" period of disability in that they provide a transitional period for assessing an individual's work potential and providing treatment and rehabilitation.

For example, German laws and policies require that all applicants for disability benefits be evaluated for rehabilitation and return to work. Based on the principle that intervention should occur at the earliest

possible stage of disability to minimize the degree and effect of the impairment, intervention in Germany often begins when the health insurance agency urges a disabled worker receiving short-term benefits to apply for medical rehabilitation. In addition, vocational counselors often discuss rehabilitation and return-to-work plans with disabled workers while they are still in the hospital. The social insurance office then evaluates the person's capacity to work and, if necessary, refers the applicant to vocational rehabilitation or other types of return-to-work services and assistance. These return-to-work measures may include assistance in retaining or obtaining a job or in selecting an occupation. They may also involve providing basic training or retraining to prepare for an occupation and developing workplace accommodations. As long as the person continues to receive short-term disability benefits, the social insurance office will monitor the case and periodically reassess the person's work capacity and need for return-to-work assistance. The office will award long-term disability benefits only after it determines that a person's earning capacity cannot be restored through return-to-work interventions.

Under Swedish laws and policies, both the private and public sectors are responsible for the early identification of candidates for rehabilitation and return to work. After an employee has been on sick leave for 4 weeks, employers are responsible for determining whether the employee needs some type of rehabilitation and are required to report this information to the social insurance office. Social insurance offices closely monitor the use of short-term benefits and intervene when employers disregard their early intervention responsibilities.[13] The social insurance office then begins the process of determining whether the person will need vocational rehabilitation to return to work. The office arranges for an assessment of the disabled employee's rehabilitation needs and works with the employer and employee to develop a rehabilitation plan. Rehabilitation in Sweden is not meant to be a lengthy process, but rather a short, intensive period of medical and vocational training to help the individual return to work as soon as possible. As in Germany, the social insurance offices in Sweden periodically monitor and reassess the rehabilitation needs of individuals receiving short-term disability benefits and, after the first year of benefits, consider granting long-term benefits if the person's rehabilitation potential has not improved.

[13]Social insurance offices in Sweden have no mechanisms or sanctions to force employers to comply with their rehabilitation responsibilities. We reported in 1996 that, according to social insurance office surveys, employers do not arrange for rehabilitation examinations in about 40 to 50 percent of the cases.

In The Netherlands, the employer has had increasing responsibility for efforts to return the employee to his or her current job or a comparable job within the company since the mid-1990s. This shift of responsibility from the public to the private sector is intended to encourage greater responsibility on the part of employers in the prevention and prompt amelioration of employee health impairments. Under this policy, within about 3 months of the onset of the disability, the employer must submit to the social insurance agency a preliminary plan to return the disabled worker to the workforce. A final plan must be submitted within about 9 months. If the employer determines that the disabled worker cannot return to the workplace, or if the disabled worker has not returned to work after 1 year of receiving short-term benefits, the social insurance agency assesses the person's condition to determine eligibility for long-term disability benefits. The assessment involves evaluations of the applicant's physical and mental capabilities, which are then matched against different occupations to determine whether the person is capable of performing any work.

SSA Does Not Incorporate Return-to-Work Efforts Into Its Eligibility Assessment Process

Unlike the private sector and foreign countries, SSA does not integrate efforts to return individuals to work into either its initial or continuing eligibility assessment process. To be considered initially eligible for DI benefits, applicants must meet the Social Security Act's definition of disability—an "all-or-nothing" definition that characterizes individuals as either unable to work or having the capacity to work.[14] Because the result of the decision is either full award or denial of cash benefits, applicants have a strong incentive to emphasize their limitations to establish their inability to work and a disincentive to demonstrate any capacity to work. The act's definition of disability—under which a person is unable to do any substantial work in the national economy—is comparable to the private sector's most restrictive definition.

[14]There are also distinct differences between the methods used by SSA and the private insurers to determine a level of earnings beyond which an individual no longer qualifies for benefits. SSA regulations, on one hand, apply a standard level of countable monthly income for all people other than the blind (currently $700), regardless of predisability earnings. In contrast, the private insurers we studied establish an individualized level that is a proportion of each person's predisability earnings. For disabled beneficiaries with high predisability earnings, the private sector's individualized level represents a much greater incentive to work than does SSA's standard level. However, the private sector's individualized level may provide less of a barrier to qualify for benefits and thus may encourage more people to apply for disability benefits.

In recent years, SSA has piloted numerous initiatives to redesign and thereby improve its disability determination process. But while an internal SSA evaluation recently recommended that the agency "create an awareness and attitudinal change to accept employment support as a core SSA mission," the agency has not yet integrated return-to-work considerations into its efforts to redesign its disability determination process.[15] Moreover, the recently enacted Ticket to Work Act was intended to increase beneficiary access to vocational services but does not change the point in the process at which beneficiaries may receive assistance. Only those individuals who have met the Social Security Act's definition of disability and are approved for DI benefits will, under the Ticket to Work Act, receive a ticket entitling them to receive return-to-work services. There can be a long delay in receiving services: SSA's eligibility determination process ranges up to 18 months or longer for individuals who are initially denied benefits and who then appeal. Since many applicants have been unemployed before applying and remain unemployed during the eligibility determination process, it is likely that their skills, work habits, and motivation to work deteriorate during this wait, thus decreasing their readiness to work.[16] However, the Ticket to Work Act authorizes SSA to carry out a demonstration project to test the advantages and disadvantages of earlier referral of applicants and beneficiaries for rehabilitation.[17] SSA may also gain additional insights into early intervention approaches through its funding of demonstration projects in 12 states.[18]

[15]Social Security Administration, *Employment Support Concept Development Plan*, Apr. 12, 1999.

[16]See GAO/HEHS-96-62, Apr. 24, 1996.

[17]SSA has not yet designed such a project, and it is unclear how early SSA will be intervening after onset of disability in this demonstration.

[18]For example, one state is testing the provision of short-term vocational services to DI applicants with recent work histories, with an emphasis on early intervention and quick employment.

Other Systems Provide Incentives for Claimants and Employers to Encourage and Facilitate Return to Work

To facilitate return to work, all of the insurers and the countries we studied employ incentives both for claimants to participate in vocational activities and receive appropriate medical treatment, and for employers to accommodate claimants. For claimants who could benefit from vocational rehabilitation, insurers and the countries we studied require participation in an individualized return-to-work program. They alsoprovide financial incentives to promote claimants' efforts to become rehabilitated and return to work. To better ensure that medical needs are met, the insurers and the countries we studied require that claimants receive appropriate medical treatment and assist them in receiving this treatment. In addition, they provide financial incentives to employers to encourage them to provide work opportunities for claimants. Although these practices are common to the private sector insurers and the countries we examined, limited data exist to determine whether these incentives for claimants and employers yield positive outcomes. In contrast to the practices of other systems, the Ticket to Work Act makes participating in rehabilitation and return-to-work services voluntary for DI beneficiaries. In addition, under law and SSA regulations, receiving appropriate medical treatment is not a prerequisite for award or continuing receipt of DI benefits. Moreover, DI applicants and beneficiaries may not have access to appropriate medical care.

Private Insurers Offer Incentives to Claimants and Employers to Promote Return to Work

All the private insurers we reviewed require claimants who could benefit from vocational rehabilitation to participate in a customized program or risk loss of benefits. As part of this program, the return-to-work plan for each claimant can include, for example, adaptive equipment, modifications to the work site, or other accommodations. All the private insurers mandate the participation of claimants whom they believe could benefit from rehabilitation, because they believe that voluntary compliance has not encouraged sufficient claimant participation in these plans.[19].

These insurers also make special financial incentives available to claimants who participate in rehabilitation programs, as appropriate. All insurers may defray costs associated with rehabilitation, such as child care expenses. For example, one insurer may pay $250 a month per child, up to $1,000 per month. This insurer also increases claimants' benefit payments

[19]Although claimants may be involved in the development of the individualized rehabilitation plans, the insurers make the final decision as to the types of rehabilitation services claimants will receive.

by 10 percent, up to a maximum of $1,000 a month, for those who participate in rehabilitation.

In addition, all of the insurers told us that they encourage rehabilitation and return to work by allowing claimants who work to supplement their disability benefit payments with earned income.[20] During the first 12 or 24 months of receiving benefits, depending upon the particular insurer, claimants who are able to work can do so to supplement their benefit payment and thereby receive total income of up to 100 percent of predisability earnings.[21] After this period, if the claimant is still working, the insurers decrease the benefit amount so that the total income a claimant is allowed to retain is less than 100 percent of predisability income.

However, when a private insurer determines that a claimant is able, but unwilling, to work, the insurer can reduce or terminate the claimant's benefits. Moreover, to encourage claimants to work to the extent they can, even if only part-time, two of the insurers may reduce a claimant's benefit by the amount the claimant would have earned if he or she had worked to maximum capacity. One insurer uses the claimant's physician or three independent experts qualified to evaluate the claimant's condition to determine a claimant's maximum capacity to work. One of the insurers may also reduce a claimant's monthly benefit during the first year by the amount that the claimant could have earned if he or she had not refused a reasonable job offer—that is, a job that was consistent with the claimant's background, education, and training. Claimants' benefits may also be terminated if claimants refuse to accept a reasonable accommodation that would allow them to work. For example, if a claimant with impaired vision refuses the offer of a large-screen terminal that would allow the claimant to work, the insurer can terminate his or her benefits.

[20]The private disability insurers we reviewed told us that their benefits generally replace 60 percent of predisability earnings, depending upon the insurer.

[21]To illustrate, assume that Ms. Jones is a claimant with predisability earnings of $1,000 per month and an insurance policy that replaces 60 percent of her predisability earnings. She is currently not working. Under this scenario, her income would be limited to $600 per month in disability benefits. However, if she returned to work, even part-time, she would have the opportunity to increase her total income to 100 percent of her predisability earnings or, in this instance, $1,000. If she returned to work and earned $500 per month, the insurer would reduce her benefit payment from $600 to $500 per month, so that her combined earnings and benefit payment would provide a total monthly income equal to her predisability income of $1,000.

Since medical improvement or recovery can also enhance claimants' ability to work, the private insurers we studied not only require, but also help, claimants to obtain appropriate medical treatment. To maximize medical improvement, private insurers require that the claimant's physician be qualified to treat the particular impairment. Additionally, two insurers require that treatment be provided in conformance with medical standards for type and frequency. Moreover, to help ensure that a claimant is receiving appropriate treatment, the insurers' medical staff work with the treating physician as needed to ensure that the claimant has an appropriate treatment plan. The insurers may also provide funding for those who cannot otherwise afford treatment.

All private sector insurers we studied may also provide financial incentives to employers to encourage them to provide work opportunities for claimants. By paying for accommodations and offering lower insurance premiums to employers, private insurers encourage employers to become partners in returning disabled workers to productive employment. For example, to encourage employers to adopt a disability policy with return-to-work incentives, all the insurers offer employers a discounted insurance premium that they can continue to receive if their disability caseload declines to the level expected for those companies that assist claimants in returning to work. To this end, these insurers fund accommodations, as needed, for disabled workers at the employer's work site. [22]

Other Countries Also Provide Incentives to Claimants and Employers to Encourage Return to Work

Germany and Sweden also require participation in rehabilitation. Individuals there may be denied benefits for not participating in rehabilitation when it is recommended by the social insurance offices. Both these countries, as well as The Netherlands, also provide financial incentives to encourage participation in rehabilitation. For example, they provide supplementary benefits to cover rehabilitation-related expenses, such as transportation and housing costs and the cost of educational

[22]Educating employers about the size and extent of disability costs is an important element in motivating the employer to promote efforts to return claimants to work. For example, private insurers educate employers about the direct and indirect costs of not controlling lost time associated with disability, which was estimated by one insurer to be 4 to 6 percent of an employer's payroll.

courses, books, and study aids.[23] Germany and Sweden also offer transitional work opportunities that enable people with disabilities to return to work part-time while earning disability benefits. These individuals can gradually increase their daily work hours, and thus their earnings, until they reach their maximum work capacity, with a corresponding decrease in benefits.[24] Similarly, The Netherlands provides a supplemental wage to beneficiaries who work, allowing them to earn a wage equal to their predisability earnings. The countries we studied also provide appropriate medical treatment and rehabilitation services to disabled individuals, and social insurance offices in Germany and Sweden may terminate the disability benefits of individuals who refuse to follow such medical recommendations.

In addition, Germany, Sweden, and The Netherlands provide financial assistance to employers for the purchase of workplace accommodations needed by disabled employees. For example, such assistance may pay for technical aids, special staff or personal assistants to help a disabled worker perform various work functions, or adaptations of the work environment to meet the special needs of a disabled worker. These countries also offer financial incentives for the employment of disabled individuals by subsidizing the wages that employers pay them. Wage subsidies are provided for a time-limited period of 3 to 4 years, with the amount of the subsidy declining each year.[25] Furthermore, in The Netherlands, employers have an additional incentive to assist employees in returning to work because the employers' contributions to the disability insurance fund are partially determined by the number of their employees who became disabled in the prior year.

[23]Germany and Sweden also promote disabled workers' efforts to return to work by providing them with financial assistance to purchase technical aids; workplace adaptations; and other work-related needs, such as personal assistants or payment of transportation costs. Additionally, Sweden provides grants to subsidize the purchase or modification of a vehicle if it is considered necessary for vocational training or for traveling to work.

[24]In Sweden, individuals with reduced work capacity may work full-time and still take part in the transitional work program.

[25]In Sweden, wage subsidies may be maintained at the same level and extended beyond the 4-year period if authorities determine it is appropriate.

SSA's Return-to-Work Incentives Are More Limited Than Those Used in Other Systems

In contrast to the private sector and the countries we studied, SSA's disability programs do not require rehabilitation for beneficiaries, regardless of their capacity to work. Instead, the recently enacted Ticket to Work Act establishes a voluntary system that depends upon the beneficiary's motivation to pursue rehabilitation services. Thus, a beneficiary who could benefit from rehabilitation might not choose to seek such services. Further, in contrast to the private sector requirement that an individual work to his or her maximum capacity, the Social Security Act does not have such a requirement, which may act as a disincentive to work. In particular, beneficiaries with low earnings may find it more financially advantageous to periodically stop working, or work part-time and continue to receive disability payments, than to earn more than SSA's limit of $700 a month in countable income and lose all cash benefits after completing a trial work period. In recognition of the potential work disincentive from this all-or-nothing benefit structure, the Ticket To Work Act requires SSA to conduct demonstration projects under which benefits are reduced by $1 for each $2 of a beneficiary's earnings above a level determined by SSA.

SSA also differs from the private sector and the countries we studied in requiring medical treatment. The Social Security Act, along with SSA regulations, requires that benefits be denied when an individual fails, without good cause, to follow treatment prescribed by his or her physician.[26] However, if an applicant is not receiving treatment, SSA still assesses the applicant's eligibility for benefits and—if the applicant qualifies—awards benefits, even if the applicant would not qualify for benefits if treated. And unless medical treatment is prescribed, it is not a prerequisite for continued receipt of benefits once they have been awarded. Indeed, SSA found in 1999 that some beneficiaries with affective disorders—who constitute one of the fastest-growing groups on the DI rolls—were receiving no medical treatment. However, SSA has recently begun a demonstration project to determine whether providing access to the right medical treatment for beneficiaries with affective disorders will

[26]For benefits to be denied, treatment must be prescribed by the individual's treating physician (the licensed physician who attends to an individual's medical needs). When an individual has no attending physician, the treating physician is the hospital or clinic where the individual goes for medical care.

enable them to return to work.[27] Nevertheless, access to medical treatment may be limited for many DI applicants and beneficiaries.[28]

In contrast to the private sector and The Netherlands, SSA does not have the legal authority to use financial incentives to encourage employers to assist those with disabilities to return to work, thus limiting the agency's ability to influence employers. SSA, however, is currently funding demonstration projects in 12 states to develop ways to increase employment of DI beneficiaries and other people with disabilities and is looking to employers for help. For example, a goal of one state project is to solicit employer views on barriers to hiring DI beneficiaries and identify strategies for, and educate employers about, increasing employment opportunities for DI beneficiaries. In addition, the federal government provides tax incentives, and states may provide other assistance to employers to encourage them to return people with disabilities to work.[29]

[27]In addition, many beneficiaries with affective disorders were not being treated by mental health professionals. Yet, research suggests that as many as 60 percent of affective disorder cases can be controlled with appropriate treatment, and SSA believes that providing appropriate medical treatment to beneficiaries with affective disorders could help them return to work. Outside of the ongoing demonstration project, SSA does not routinely intervene in the delivery of medical services for its beneficiaries.

[28]DI applicants may not be covered by health insurance. In addition, new DI beneficiaries have a 24-month waiting period before Medicare eligibility. Moreover, Medicare generally does not cover the costs of certain treatment—such as prescription drugs—that may be necessary to improve functioning for a return to work.

[29]For example, small businesses may take an annual tax credit for a variety of costs incurred in providing employee accommodations, such as readers, sign language interpreters, and adaptive equipment. Also, all businesses may take an annual deduction for the expense of removing physical, structural, and transportation barriers to disabled workers. Further, state vocational rehabilitation agencies can provide various services to employers, such as rehabilitation engineering services for architectural barrier removal and work site modifications.

Other Systems Strive to Use Appropriate Staff to Achieve Accurate Disability Decisions and Successful Return-to-Work Outcomes

Officials of each of the disability insurers and countries that we studied told us that they have developed techniques for using the right staff to assess eligibility for benefits and return those who can to work. Both the insurers and the countries have access to individuals with a range of skills and expertise. Moreover, officials told us that they selectively apply this expertise as appropriate to cost-effectively assess and enhance claimants' capacity to work. In contrast, SSA's DDS teams of medical and psychological consultants and disability examiners are hired and trained to assess eligibility of applicants to receive cash benefits rather than to enhance claimants' capacity to work. As a result, the staff of SSA and the DDSs do not have the expertise to carry out the role of returning disabled workers to productive employment.

Private Insurers Seek to Use Appropriate Staff to Assess Eligibility and Provide Return-to-Work Services

Each of the private disability insurers that we studied has access to multidisciplinary staff with a wide variety of skills and experience who can assess claimants' eligibility for benefits and provide needed return-to-work services to enhance the work capacity of claimants with severe impairments. The private insurers' core staff generally include claims managers, medical experts, vocational rehabilitation experts, and team supervisors.[30] The insurers explained that they set hiring standards to ensure that these multidisciplinary staff are highly qualified. Such qualifications are particularly important because assessments of benefit eligibility and work capacity can involve a significant amount of professional judgment when, for example, a disability cannot be objectively verified on the basis of medical tests or procedures or clinical examinations alone.[31] Table 4 describes the responsibilities of this core staff of experts employed by private disability insurers, as well as its general qualifications and training.

[30]The insurers also employ disability income specialists to assist claimants in applying for DI benefits.

[31]According to one insurer, disabilities with subjective diagnoses include certain types of mental illness, fibromyalgia, chronic pain (often back pain), and chronic fatigue syndrome.

Table 4: Responsibilities and Qualifications of Staff Employed by Disability Insurers to Assess and Enhance a Claimant's Work Potential

Type of staff	Responsibilities	Qualifications and training
Claims managers	-- Determine disability benefit eligibility. -- Develop, implement, and monitor an individualized claim management strategy. -- Serve as primary contact for the claimant and the claimant's employer. -- Focus on facilitating the claimant's timely, safe return to work. -- Coordinate the use of expert resources.	One insurer gives preference to those with a college degree and requires insurance claims experience and specialized training and education. Another requires a college degree, a passing grade on an insurer-sponsored test, and specialized training and coaching.
Medical and related experts[a]	-- Collect and evaluate medical and functional information about the claimant to assist in the eligibility assessment and help to ensure that claimants receive the appropriate medical care to enable them to return to work. -- At one insurer, physicians also help train company staff.	Medical staff include registered nurses with case management or disability-related experience and experts in behavioral and mental issues, such as psychologists, experienced psychiatric nurses, and licensed social workers. Two insurers also employ board-certified physicians in various specialties.[b]
Vocational rehabilitation experts	-- Help assess the claimant's ability to work. -- Help overcome work limitations by identifying needed assistance, such as assistive devices and additional training, and ensuring that it is provided.	Rehabilitation experts are masters-level vocational rehabilitation counselors. In addition, one insurer requires board-certification and 5 years of experience.
Supervisors	-- Provide oversight, mentoring, and training.	One insurer gives preference to those with a college degree and requires 3 years' disability experience, some management experience, and specialized training. Another insurer requires a college degree, more than 12 years' disability claims experience, and completion of courses leading to a professional designation.

[a]In one company, the medical expert is an employee of a company subsidiary but is often colocated with the insurers' employees.

[b]One company, for example, employs 85 part- and full-time physicians, including psychiatrists, doctors of internal medicine, orthopedists, family practice physicians, cardiologists, doctors of occupational medicine, and neurologists.

The disability insurers we reviewed use various strategies for organizing their staff to focus on return to work, with teams organized to manage claims associated either with a specific impairment type or with a specific employer (that is, the group disability insurance policyholder). One insurer organizes its staff by the claimant's impairment type—for example, cardiac/respiratory, orthopedic, or general medical—to develop in-depth staff expertise in the medical treatments and accommodations targeted at overcoming the work limitations associated with a particular impairment. The other two insurers organize their staff by the claimant's employer, because they believe that this enables them to better assess a claimant's job-specific work limitations and pursue workplace accommodations.

including alternative job arrangements, to eliminate these limitations.[32] Regardless of the overall type of staff organization, each of the insurers facilitates the interaction of its core staff—claims managers, medical experts, and vocational experts—by pulling these experts together into small, multidisciplinary teams responsible for managing claims. Additionally, one insurer engenders team interaction by physically colocating core team members in a single working area.

The disability insurers expand their core staff through agreements or contracts with subsidiaries or other companies to provide a wide array of needed experts. These experts—deployed both at the insurer's work site and in the field—provide specialized services to support the eligibility assessment process and to help return claimants to work. For instance, each insurer we studied contracts with medical experts beyond its core employee staff—such as physicians, psychologists, psychiatrists, nurses, and physical therapists—to help test and evaluate the claimant's medical condition and level of functioning. In addition, the insurers contract with vocational rehabilitation counselors and service providers for various vocational services, such as training, employment services, and vocational testing.[33]

All of the private insurers we examined told us that they strive to apply the appropriate type and intensity of staff resources to cost-effectively return to work claimants with work capacity. The insurers described various techniques that they use to route claims to the appropriate claims management staff, which include separating (or "triaging") claimants with work potential and directing their claims to staff with the appropriate expertise. According to one insurer, the critical factor in increasing return-to-work rates and, at the same time, reducing overall disability costs is proper triaging of claims. In general, the private insurers separate claims by those who are likely to return to work and those who are not expected to return to work. The insurers told us that they assign the type and

[32]All three insurers, however, have behavioral care specialists specifically for managing psychiatric claims.

[33]Two insurers also contract with investigators and surveillance personnel to investigate potential inconsistencies between the claimant's statements and actual activities. One company employs field-based investigators who verify claimant information and assess the conformance of the claim to observed claimant activities. These investigators usually have prior investigative experience and receive ongoing training on current medical issues and other professional education.

intensity of staff necessary to manage claims of people who are likely to return to work on the basis of the particular needs and complexity of the specific case. This selective staff assignment is shown in table 5.

Table 5: Triage of Claims and Illustrations of Selective Staff Assignment for Claims Management

Triage category	Staff assigned	Types of return-to-work services provided
Likely to return to work		
-- Condition requires medical assistance and more than 1 year to stabilize medically.	Medical specialist	-- Recommend improvements in treatment plan to treating physician. -- Refer claimant for more specialized or appropriate medical services. -- Ensure frequency of treatment meets standards for condition.
-- Condition requires less than a year to stabilize.	Claims manager	-- Monitor medical condition. -- Maintain contact with employer and physician to ensure return to work. -- Obtain input from medical and vocational specialists as needed.
-- Condition is stabilized and claimant needs rehabilitation or job accommodation to return to work.	Multidisciplinary team including -- Vocational expert -- Medical expert -- Claims specialist -- Specialists as needed	-- Evaluate claimant's functional abilities for work. -- Customize return-to-work plan. -- Arrange for needed return-to-work services. -- Monitor progress against expected return-to-work date.
Unlikely to return to work		
-- Claimant is determined unable to return to work.	Claims manager	-- Review medical condition and level of functioning regularly.

As shown in table 5, claimants expected to need medical assistance, such as those requiring more than a year for medical stabilization, are likely to receive an intensive medical claims management strategy. A medical strategy involves, for example, ensuring that the claimant receives appropriate medical treatment. Claimants who need less than a year to stabilize medically are managed much less intensively. For these claims, a claims manager primarily monitors the claimant's medical condition to assess whether the claimant has stabilized sufficiently medically to begin vocational rehabilitation, if appropriate. Alternatively, claimants with a more stable, albeit serious, medical condition who are expected to need vocational rehabilitation, job accommodations, or both to return to work might warrant an intensive vocational strategy. The private disability insurers generally apply their most resource-intensive, and therefore most expensive, multidisciplinary team approach to these claimants. Working closely with the employer and the attending physician, the team actively pursues return-to-work opportunities for claimants with work potential.

Finally, claimants who are likely not to return to work (or "stable and mature" claims) are generally managed using a minimum level of resources, with a single claims manager responsible for regularly reviewing a claimant's medical condition and level of functioning.[34] The managers of these claims carry much larger caseloads than managers of claims that receive an intensive vocational strategy. For example, one insurer's average claims manager's caseload for these stable and mature claims is about 2,200 claims, compared with an average caseload of 80 claims in the same company for claims managed more actively.

Regardless of the category into which a claim is placed, the claims manager is responsible for identifying the appropriate experts and involving them in the management of the claim as an essential element of developing and implementing a customized claims management strategy. The claims manager may informally use the assistance of experts or hold an interdisciplinary team meeting, including clinical and rehabilitation experts, to obtain advice on developing the claims management strategy and help in determining which specialized experts need to be deployed to manage the claim. Further, if the claims manager refers the claim to a specialist, that specialist may determine that additional expertise is required as well. But the insurers told us that they escalate a claim to staff with progressively more training and specialization, and thus higher cost, only if needed to resolve increasingly complex claims management issues. To ensure that staff are utilized cost-effectively, the private insurers said that they compute the return-on-investment accruing from investing in return-to-work resources for a particular claimant.

Other Countries Also Selectively Apply Specialized Staff to Return Claimants to Work

Other countries' social insurance offices also call upon various specialists, such as physicians, vocational experts, and psychologists, in the process of evaluating and enhancing a person's ability to work. If the needed expertise is unavailable in-house, the social insurance agency may purchase the necessary services from other organizations. The expertise applied is decided on a case-by-case basis depending on the case's complexity. For example, the social insurance offices in Sweden are responsible for working with the regional and local employment and rehabilitation offices to determine the appropriate types of rehabilitation services for a claimant. Medical assessments of work capacity in Germany

[34]One of the insurers reviewed cases of claimants who were not expected to recover medically and to remain work-disabled for the duration of the policy every 12 to 36 months.

and The Netherlands may also be supplemented by advice from vocational or other experts.

Social insurance offices in Germany and Sweden select the appropriate staffing and services to dedicate to particular cases on the basis of the likelihood of a successful outcome. The staff assignments made and the return-to-work actions taken by the social insurance offices depend on an assessment of each applicant's potential for returning to work. In complex cases of potential long-term disability, more extensive evaluations involving psychologists and vocational specialists may be conducted to assess the work capacity of an applicant. In Germany, medical rehabilitation is provided before an applicant's condition is assessed to determine whether vocational rehabilitation is necessary. Only if successful rehabilitation seems unlikely, or if rehabilitation has been provided without success, will the social insurance offices in Germany and Sweden typically grant the person long-term disability benefits. But, in contrast with the private insurers we examined, once an individual is granted long-term benefits and therefore considered too severely disabled to benefit from services, the social insurance offices rarely reassess the person's return-to-work potential and generally do not offer any return-to-work services or benefits.

The Netherlands also dedicates resources to evaluating return-to-work potential and providing rehabilitation services on the basis of the particular return-to-work potential and needs of individuals. But unlike Germany and Sweden, The Netherlands offers vocational rehabilitation to disability beneficiaries who choose to pursue a work goal even after they are granted long-term benefits.

SSA Staff Are Not Focused on Returning Claimants to Work

In contrast to the private insurers and the foreign social insurance offices, the focus of DDS staff who make determinations for SSA is to assess the eligibility of applicants to receive cash benefits. The DDSs do not assess what is needed for an individual to return to work or help an individual with work capacity to return to work. Neither do they ensure that DI applicants or beneficiaries receive medical treatment. To make initial benefit eligibility determinations, DDSs rely on teams comprising a disability examiner and a medical or psychological consultant. Since the DDS teams do not carry out the variety of roles related to return to work, they do not include staff with the vocational skills and expertise who are incorporated in teams used by the private and foreign disability systems. However, under the Ticket to Work Act, beneficiaries who voluntarily choose to attempt a return to work may tap into vocational expertise

outside SSA that could provide the additional services, expertise, and supports to help them in their effort, but only after benefit award.

Moreover, while SSA funds the state DDSs, SSA's regulations delegate authority to each DDS to set hiring policies and determine how to organize staff charged with carrying out the eligibility assessment function. Consequently, in contrast to the standardized hiring practices used by the private insurers, considerable variation can exist among the states in the requisite qualifications for hiring key staff. For example, among the DDSs, the required educational background for disability examiners ranges from a high school diploma to some college to a college degree.

In addition, SSA separates beneficiaries into groups according to their likelihood of medical improvement for the purpose of assessing continuing eligibility for benefits, in accordance with law and regulation. The agency invests greater staff resources in reviewing beneficiaries who are most likely to medically improve than in reviewing those with less likelihood of improvement. In contrast to practices of the private insurers and foreign social insurance offices, SSA uses its resources to determine continuing eligibility on the basis of medical improvement and does not separately evaluate whether a beneficiary has the potential to return to work.[35]

Concluding Observations

Return-to-work practices used in the U.S. private sector and in other countries reflect the understanding that people with disabilities can and do return to work. In 1996, we recommended that SSA place greater priority on helping disabled beneficiaries return to work. We also recommended that the agency develop a comprehensive strategy for this effort. While SSA has begun to focus more on return to work, it has yet to adopt a comprehensive strategy for implementing this new approach. For example, it has yet to integrate its return-to-work efforts with its initiatives to improve the disability decision-making process. In short, we continue to believe SSA is still not placing enough priority on identifying and enhancing the work potential of its beneficiaries with disabilities. We also continue to believe that SSA could do this more effectively without jeopardizing the availability of benefits for people who cannot work.

[35]The law contains several exceptions that allow benefits to be terminated even when a person's medical condition has not improved. For example, benefits may be disallowed when new or improved diagnostic techniques reveal that the impairment is less disabling than originally determined.

We acknowledge that limited data exist on the cost-effectiveness of the return-to-work approaches used in the other systems we examined. In addition, SSA may face greater difficulty in returning some of its beneficiaries to work than private sector insurers do, since DI covers a broader population than the private insurers. Moreover, significant differences exist between SSA's disability programs and those of private sector disability insurers and social insurance programs in other countries. Some of these differences can be attributed to the particular laws and regulations governing the programs. Although SSA would face substantial constraints and challenges in applying the return-to-work practices of other programs, we believe opportunities exist for providing the return-to-work assistance that could enable more of SSA's beneficiaries to reduce or eliminate their dependence on cash benefits.

The Congress recognized the need to focus more on return to work when it passed the Ticket to Work Act, which authorizes and requires SSA to conduct return-to-work demonstration programs. Program managers and policymakers will be able to learn from the experiences of these demonstrations, and they can also draw upon the approaches of the other systems to further strengthen and enhance a comprehensive return-to-work focus. Adopting such a focus will, however, require fundamental changes to the underlying philosophy and direction of the disability programs, including the determination of disability. Policymakers will need to carefully weigh the implications of such changes, but compelling reasons exist to try new approaches. Current estimates project that the DI trust fund will become insolvent in 2023. This financial strain, along with advances in technology and medicine that can help individuals improve their productive potential, provides ample reason for examining how practices from other systems could be applied to improve SSA's return-to-work outcomes.

Mr. Chairman, this concludes my prepared statement. I would be pleased to respond to any questions you or Members of the Subcommittee may have.

GAO Contact and Staff Acknowledgments

For future contacts regarding this testimony, please call Barbara D. Bovbjerg at (202) 512-7215. Carol Dawn Petersen, Barbara H. Bordelon, Kelsey M. Bright, Julie M. DeVault, William E. Hutchinson, and Mark Trapani also made key contributions to this testimony.

Related GAO Products

Social Security Disability Insurance: Raising the Substantial Gainful Activity Level for the Blind (GAO/T-HEHS-00-82, Mar. 23, 2000).

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